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Planning effective mental healthcare in prisons using the Care Programme Approach and the Community Mental Health Framework

Quality Network for Prison Mental Health Services

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Painting

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Summary

Within inpatient and community settings, the Care Programme Approach (CPA)* can be an effective tool in coordinating support, care and treatment around a person's mental health and learning disability needs. However, there are wide variations in implementation across the country.

There are intentions to gradually replace CPA, whilst retaining the basic principles, with a new approach called Personalised Care and Support Planning[1], as part of the wider implementation of the Community Mental Health Framework for Adults and Older Adults (CMHF) (NHS England and NCCMH, 2019).

Within prison settings, CPA has been poorly implemented and the principles underpinning the approach have been lost. This is evidenced by the reporting of national aggregated data by the Quality Network for Prison Mental Health Services[2], as well as by various clinical research papers (Brooker and Webster, 2017; Brooker and Forrester, 2017; OHRN, 2009). Following a consultation with prison and community mental health services, this document has been developed to offer further guidance and support around the key principles of CPA.

Many mental health services in prisons experience significant resource and operational challenges. For these principles to be executed effectively, services require adequate resources and facilities, including access to up-to-date technology, including video conference facilities, and for patients to be located closer to their home area. This guidance calls for improvements in these areas. Due to the identified challenges, parts of the guidance contained within this document must currently be aspirational only.

To properly implement CPA in prisons will require:

- Clarity about processes and eligibility across prison mental health teams nationally
- Common documentation to enable information transfer and reduce form filling
- Resources including administrative support within prison mental health teams
- Greater use of video conferencing for CPA meetings
- Agreements with local mental health trusts about transfers between community and prison services
- Greater involvement of patients in the CPA process

[1] https://www.england.nhs.uk/ourwork/patient-participation/patient-centred/planning/

[2] www.qnpmhs.co.uk

*CPA applies in England; the other nations and devolved administrations in the UK, and the Republic of Ireland, have alternative frameworks.

- Better coordination with the criminal justice system, especially probation

Purpose

The purpose of this document is to standardise the CPA and successor processes, and to ensure consistency within and between prisons and through transfers from and to community services. The guidance will also be useful for immigration removal centres.

What is CPA?

Introduced in 1991, the CPA aims to improve care for people with mental illness at a time when the transfer of care from hospitals to the community was perceived as failing. It was strengthened as part of the *Ten Point Plan* for mental health, which led to the introduction of Supervised Discharge (a precursor to Community Treatment Orders) in response to several homicides and other incidents involving people with mental illness who were perceived to have had inadequate care following discharge from hospital (Department of Health, 1995).

The latest guidance available on CPA is in the form of a Rethink Factsheet (September 2017), available online and directed to from the NHS website[3]. It describes CPA as a framework for assessing secondary mental health needs and coordinating care. Important elements of the framework are ensuring continuity of care, joint working and good information sharing. The patient is at the centre of the process and is supported to take ownership of their recovery. In addition, patients subject to CPA require an annual physical health check.

What is the Community Mental Health Framework?

Published in September 2019, this document outlines planned changes in community mental health services and the replacement of CPA, along with significant extra investment of almost £1 billion a year by 2023/2024.

The new framework seeks to address several problems, including:

- transfers between services;
- 50 per cent of referrals to community mental health teams come from sources other than primary care;
- 20 per cent of proposed transfers do not reach the new team; and
- populations excluded by diagnosis, complexity, or risk.

The framework will be applicable to people irrespective of their diagnosis. This includes but is not limited to those with:

- coexisting frailty (likely in older adults);
- coexisting neurodevelopmental conditions;
- eating disorders;
- common mental health problems, such as anxiety or depression;

[3] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

- complex mental health difficulties associated with a diagnosis of "personality disorder";
- co-occurring drug or alcohol-use disorders, and other addiction problems, including gambling problems; and
- severe mental illnesses, such as psychosis or bipolar disorder.

It should also include intensive and assertive support, long-term care, and support for those who may be at risk of exclusion from their community, including:

- people leaving the criminal justice system or people with multiple vulnerabilities frequently involved with the police;
- rough sleepers;
- socially excluded people; and
- those with very complex needs, such as people with disabling psychotic disorders or people with disabling complex mental health difficulties associated with diagnosis of "personality disorder".

As stated in the framework document, it "proposes replacing the CPA for community mental health services, while retaining its sound theoretical principles based on good care coordination and high-quality care planning."

If backed up with the promised investment and expansion of community mental health services and the identification of patients with complex problems, irrespective of diagnosis, and those at risk of social exclusion, the Community Mental Health Framework has much to offer to the patient group served by prison mental health services.

Continuity of care

> *Vignette: Patient A was convicted of murder and develops bipolar disorder during their sentence. The patient also has ASD. After treatment in medium security they are transferred back to prison. They will require management of their mental health throughout the rest of their sentence, support to complete offending behaviour programmes, and multi-agency involvement, including the prison mental health team, community mental health team/community forensic team, probation, and prison when they are considered for release by The Parole Board. This would require regular CPA meetings for long-term planning of the care but may only be needed yearly.*

Continuity of care is an important factor in outcomes from severe mental illness. MacDonald et al (2019) studied patients of community services in South London over the decade 2006-2016 and concluded, "there is evidence of declining continuity of care in this 11-year study of people with schizophrenia, and of an independent effect of this on worse clinical outcomes". Continuity of care in general practice has been shown to reduce accident and emergency (A&E) attendances and hospital admissions in patients with ambulatory care sensitive

conditions; it is preferred by patients and leads to greater job satisfaction amongst GPs (Tammes and Salisbury, 2017).

A large Scandinavian cohort study (Chang et al, 2016) showed reductions in violent reoffending for released prisoners in periods when they continued psychotropic medication after release in comparison with times they didn't. The reduction in violent offences per 1000 years at risk was highest for psychostimulants in attention deficit hyperactivity disorder (ADHD) (42.8), followed by antipsychotics (39.7) and dispensed drugs for addictive disorders (36.4). Maintaining former prisoners on psychotropic medication, part of continuity of care, can be an important factor in reducing violent offending in released prisoners, as well as maintaining their mental health. There needs to be a robust mechanism for transferring shared care agreements for prescription of medications, such as antipsychotics and psychostimulants, between prison and community mental health services and prison and community primary care.

CPA and prisons

> *Vignette: Patient B has been under the long-term care of a community mental health team and managed under CPA receives a short custodial sentence for breaching a community order. Their mental health treatment needs to continue but without major changes or increases in risk. CPA should be continued throughout the sentence with communication between community and prison key workers, however a face-to-face meeting is unlikely to be required.*

Entry into the prison system, usually as a remand prisoner, represents a discontinuity in care and social support and a period of high vulnerability for self-harm, suicide, and victimisation, for many thousands of people with mental health difficulties annually. Almost half of those sentenced in 2018 had sentences of less than six months (Prison Reform Trust, 2019), with 69% of these being imprisoned for non-violent offences. Many remand prisoners will be released after being acquitted or on community sentences. Most of those remanded into prison will return to the community within six months. Their care needs are likely to remain the same or to have increased over the period. The point of release is often a period of crisis without accommodation to go to and the need to access or re-access community services; this is a time of increased suicide risk.

Even for the 48% of prisoners sentenced to between one and four years, they will usually be released between six months and two years. For those on sentences longer than four years (48% of the prison population) and indeterminate sentences (13% of the prison population), there will be transfers between prison establishments during their sentence (House of Commons Library, 2019). This necessitates transfers of care between prison mental health teams and care planning on release. The prison system is also unpredictable,

and prisoners can be moved at short or no notice due to overcrowding, disciplinary issues etc.

Given the importance of continuity in care, the vulnerability and increased risks for those with mental health difficulties, a system for mitigating discontinuities in care, such as CPA, could be an effective tool in improving health outcomes and managing risk. CPA is however widely underused in the prison system. Deficits in continuity of care, particularly on release, have been widely reported. For example, the National Audit Office (NAO) report on mental health in prisons identified problems in continuity between prisons and between prison and the community with barriers including: distance from home; information-sharing; lack of notice; inability to prepare for release; and availability of services in the community (2017).

Eligibility for CPA

> *Vignette: Patient C has a diagnosis of emotionally unstable personality disorder and complex PTSD. They frequently enter the local remand prison for short sentences and licence recalls. They often present with serious self-harm and psychotic/pseudo-psychotic symptoms associated with NPS use. The prison mental health team has developed a good relationship with them. They prescribe an SSRI (selective serotonin reuptake inhibitor) and low dose antipsychotics and stabilise them, but they are never in custody long enough to begin engaging in psychological therapy. They are then released without accommodation, are not taken on by a community mental health team, stop medication, relapse and repeat the cycle. CPA, involving representatives from community mental health, probation, housing and substance misuse services would enable long-term treatment planning to address the cycle of repeated entries into prison and hopefully achieve enough stability to engage with psychological treatment for their difficulties.*

The criteria for who is eligible for support under CPA and CMHF guidance is not realistic in a prison setting, as it would by definition apply to the majority of the prison mental health team's caseload. The following criteria has been devised to support services in identifying those most in need of support under CPA:

- Require secondary mental health services with a (working) diagnosis of a mental disorder, including personality disorder*
- Individuals currently registered to receive CPA on reception into prison
- Neurodevelopmental disorders, such as learning disabilities, autism spectrum disorder (ASD) and ADHD

**Patients with a diagnosis of personality disorder would benefit from the CPA process during periods of crisis or transition. The appropriateness of a patient being subject to the CPA process should be reviewed and reconsidered where a patient's circumstances have changed.*

In addition to these, individuals may present a range of factors that may contribute towards making a decision to provide support under CPA in complex cases:

- Severe distress now or in the past
- History of difficulties engaging with mental health services now or in the past
- Risk of self-harm or suicidal ideation, or harming other people
- Comorbid substance misuse
- Requiring support from a range of agencies in addition to mental health, such as housing, physical care, criminal justice or voluntary agencies

To be effective, CPA in prisons must be able to cope with large numbers of people with complex needs and risks of self-harm, vulnerability and risk to others. It should be a process to transfer care from community services into prisons and back again, and to assist with delivering care over long periods within the prison system. It should not be reserved solely for a very small group of highly complex and high-risk individuals within prisons.

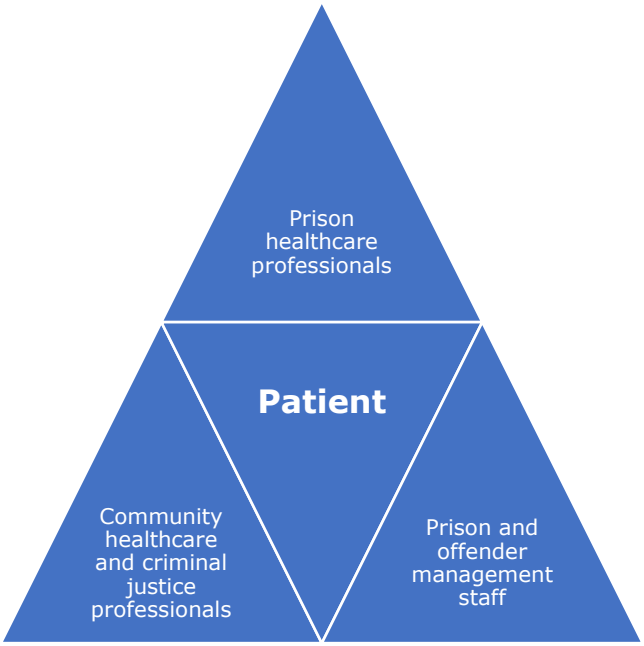
Whilst numbers of people on CPA are included in the Health and Justice Indicators of Performance (HJIPs), there is no clear definition of who should be on CPA. Recorded numbers of people on caseload are far short of what they would be if caseloads were based on the definition above. The following definition goes beyond the eligibility criteria and identifies people who should be on CPA:

- Patients in receipt of secondary mental health services and under CPA in the community should be placed on CPA on reception into prison. There should be a process of hand over and continuity of CPA and not immediate discharge by community services as the patient is somewhere else.
- Patients identified as having a mental disorder, complex needs and associated risks in prison started on CPA by prison mental health teams.
- Patients transferred from secure hospitals into the prison system after a period of inpatient treatment. This should reflect the findings of the hospital during which ongoing care needs have been identified.

CPA should be an integral component of release planning, when planning is possible, and should co-ordinate prison and community mental health teams, physical health, probation, housing, substance misuse, primary care etc. Where care relates to a young person, the relevant child and adolescent services should also be engaged.

Who should be involved?

There are a number of people who should be involved in the CPA process, including: the patient, healthcare professionals, and criminal justice professionals.



As a **minimum**, there should be a representative from the prison mental health team, the community mental health team and the prison[4].

We **recommend** the following people should be considered for involvement in CPA or multi-disciplinary recovery meetings. This list is not mandatory, but a suggestion of who could be involved.

[4] For patients cared for within the Long Term and High Secure Estate, representation should consist of professionals relevant to care and sentence planning. It may be that these meetings have a combined purpose. The level of involvement should be determined by the prison mental health team, dependent on the individual's care and treatment needs.

Dedicated administrative support, or a CPA administrator, should be in place to oversee the CPA process and ensure the process is managed effectively. This should be standard within prison health contracts to ensure effective and timely coordination.

It is acknowledged that it can be difficult to coordinate attendance by all of the necessary professionals. Mental health services in prisons should have technology available to them to enable contributions from the required professionals, such as video-conferencing facilities. The ongoing COVID-19 crisis has led to a rapid expansion of video conferencing technology making links with community services much easier.

How often should CPA meetings take place?

On being received by a mental health service, a patient should receive an initial CPA meeting within the first 28 days, at three months and every six months thereafter, or whenever any significant transition occurs.

For individuals who reside in the prison for short periods of time, the mental health service is expected to hold the case and pass on appropriate information to the receiving service on their departure. Community mental health teams should not discharge a patient whilst they are on remand or on a sentence of less than 12 months.

How can patients be encouraged to take ownership of their care?

The service-user defined CPA standards (2010) designed to encourage patients to take ownership of their care are difficult to implement in a prison setting. The following standards should be adopted, where possible:

1. The patient is included in all parts of their CPA meeting, where appropriate. Patient capacity is considered throughout the process.

2. The patient is able to discuss and agree who should be invited to their CPA meeting. The patient will be informed of the professionals that are required to attend.

3. The patient is made aware of the advocacy service and they will have the choice for advocacy support within the CPA process and meeting.

4. The patient is informed of the structure and content of the CPA meeting.

5. The patient is supported to prepare for the meeting.

6. The patient will be given the option to chair some/all of their CPA meeting or select an appropriate chair.

7. Where possible, the patient will be involved in helping to set up the room where the meeting will be held.

8. An action plan is collaboratively agreed at the end of the meeting, with clearly identified people for each goal/action point and clear timescales are set.

9. The date for the next CPA meeting and proposed attendees are agreed at the end of the meeting.

10. The patient is shown a final draft report and they are supported to add their own views and comments.

11. The patient should be spoken to directly by the people reading or summarising the report, and not spoken over.

12. All reports should be written in clear and simple language and avoiding the use of jargon.

13. Paper and pens will be available at the meeting, unless risk prohibits this.

How can we coordinate care across different services?

> *Vignette: Patient D has been remanded for a less serious violent offence. They have been assessed in the community by the crisis team, but their problems were felt to be due to novel psychoactive substance (NPS) use and treatment was not offered. Further assessment in the prison leads to a diagnosis of schizophrenia and the offence was linked to their mental illness. A mental health component to disposal, such as a Mental Health Treatment Requirement on a Community Order is a possibility. CPA would be indicated due to mental illness, link to risk, substance misuse, multi-agency involvement (prison mental health team, community mental health team, substance misuse, probation). A CPA meeting involving all the agencies would be required to develop a community care package and criminal justice management plan.*

To improve communication and joint working between services, we recommend:

- National agreement on good practice including:
    - patients are not discharged from community mental health teams when they enter prison, but their care transferred to the prison mental health team;
    - patients are not discharged from the community mental health team caseload until it is clear they will not return to the community served by the team within a year;
    - the community mental health team accept referrals of CPA patients directly from prison mental health teams (another secondary mental health service) and do not require patients to register with a GP then undergo a re-assessment for care at a time when they require continuity of care;
    - robust mechanisms for transferring shared care agreements to ensure continuity of supply of psychotropic medication; and,
    - standardised SystmOne documentation and procedures across prison mental health services.
- Local agreements between prison mental health service providers and local trusts where there are significant patient flows e.g. local remand prisons serving catchment areas.
- Greater utilisation of electronic communications, such as Skype and video link.
- Information sharing between services.
- Provision/verbal communication of guidance for people with communication or literacy issues.

Standards for Adult Community Mental Health Services (RCPsych, 2020) reflect these aspirations:

> Standard 67: Where appropriate, there is formalised joint working and information sharing arrangements in place to support continuity of care

for patients transitioning between community and prison mental health services.

Guidance:

- *Patients should be formally handed over from community to prison mental health services and not discharged when they enter custody;*
- *Patients should remain open to community team caseloads until it is clear they are not returning to the community in the near future;*
- *Community services should accept direct referrals from prison mental health services.*

Involving family and friends

Where consent has been provided, the mental health service should engage with the patient on how their family and friends/appropriate carer can be involved in their care and treatment. It is best practice to consider carer engagement as an ongoing process and to check the patient's views on what information to share and who with. Legally, carers can be given general information about the condition of the person cared for, though not specific information if the patient does not consent. Information sharing is subject to the Data Protection Act 2018 (NHS England, 2018).

Aftercare arrangements

Professionals, both within and outside the prison, should coordinate an individual's care to ensure they receive appropriate support after they leave the prison. This includes healthcare, social care and accommodation services. Aftercare services should meet needs arising from or relating to the identified mental health condition and reduce the risk of the mental health condition worsening (Mind, 2017).

How do we improve knowledge and awareness?

To improve knowledge and awareness of CPA within your prison, you can use the training slides that have been developed to accompany this guidance. The slides detail what the CPA process is and what the expectations are of each of the key parties involved (in development).

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Appendix 1: CPA timeline

The following timeline is a guide for services to use when a patient requires care under the CPA. A series of vignettes can be found in appendix 1 to illustrate how CPA should be applied in practice.

Step 1: Reception and information gathering

(Referral received from criminal justice system, community mental health team or liaison and diversion service)

CPA check at reception

> **Yes**, automatic referral to secondary screen
>
> **No**, but indications of need – trigger automatic referral

Information gathering within 24 hours/one working day

Patient to see mental health professional within defined response times in QNPMHS standards

Step 2: CPA assessment

Review documentation from last review.

Need identified:

> CPA review within 60 days (involving community mental health team – input could be verbal or in written format)

No need identified:

> Schedule CPA six months from date of last review[5]

Issue CPA passport

Complete CPA template

Plan for discharge, where appropriate

Step 3: 6-month review

Perform a review to occur 6-monthly, or as determined by clinical need

Invite relevant people to attend at least one month before, if applicable

Step 4: 12-month review

Physical health check to occur annually, or by clinical need

Step 5: Discharge

[5] For patients residing in the long-term high secure estate, CPA meetings should be scheduled annually or if there is a significant event.

Case open to community mental health team? Yes, transfer back

Case open to prison? Yes, transfer to relevant team

Referral within six weeks

Schedule CPA multi-agency handover meeting

Follow-up

Appendix 2: Developing guidance for effective mental healthcare in prisons

This guidance has been developed by the Quality Network for Prison Mental Health Services and Tees, Esk and Wear Valleys NHS Foundation Trust:

1. Literature review

A literature review and review of key documents was conducted to inform the development of the guidance. Compliance of QNPMHS member services against QNPMHS CPA standards was also reviewed.

2. Pre-event telephone interviews

Telephone interviews were conducted with 12 QNPMHS member services about their experience of using CPA in prisons.

3. Consultation

The Quality Network for Prison Mental Health Services and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) co-hosted a consultation event on 11 April 2019. The event was attended by over 70 people and included representatives from prison mental health services, community mental health services and key stakeholders. To gather experiences and feedback, TEWV facilitated discussions using a technique of solution-focused and possibility thinking. Delegates generated a wealth of information that was applied to the development of the guidance.

4. E-consultation

In October 2019, a draft of the guidance was circulated electronically to QNPMHS contacts, including: QNPMHS membership, QNPMHS distribution lists, RCPsych Forensic Faculty, NHS England, other key stakeholders and the QNPMHS advisory group.

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